**AUBURN UNION SCHOOL DISTRICT**
**255 EPPERLE LANE**
**AUBURN, CA 95603**
**PHONE 530.885.7242 FAX 885.5170**

# ASTHMA ACTION PLAN

**Dear Parent/Guardian,**
**According to your child's health records, he/she has asthma. In order to administer emergency medication at school, Part I (Physician section) and Part II (Parent section) of this form must be completed and returned to the district nurse. If you have any questions, please contact Jenny Serrano, District Nurse (jserrano@auburn.k12.ca.us)**

| **Student Name:** | | **Date of Birth:** |
|---|---|---|
| **School:** | **Grade** | **School Year:** |

**What are some triggers that might start an asthma episode for your student?**

☐Exercise ☐Pollens ☐Irritants (e.g. chalk dust) ☐Cigarette Smoke
☐Animal Dander ☐Molds ☐Emotions (e.g. when upset) ☐Strong Odors
☐Respiratory Infections ☐Temperature Changes ☐Foods: ☐Other:

**PART I: PHYSICIAN SECTION**

| **HEALTHCARE PROVIDER ORDERS (To be completed by provider authorizing treatment)** | | |
|---|---|---|
| **Name of Rescue Inhaler:** | | ☐**Have student use SPACER with inhaler** |
| **Common Side Effects:** | | |
| **GREEN ZONE**<br>**No symptoms/pretreat** | • No current symptoms<br>• Doing usual activities | Pretreat before exercise:<br>☐ Not required ☐ Routine ☐ Parent/Student request<br><br>Give RESCUE INHALER 10-15 minutes before activity:<br>☐ 2 puffs ☐ 4 puffs<br>☐ Repeat in 4 hours, if needed for additional physical activity.<br>***If child is currently experiencing symptoms, follow YELLOW ZONE*** |
| **YELLOW ZONE**<br>**Mild symptoms** | • Trouble breathing<br>• Wheezing<br>• Frequent cough<br>• Not able to do activities, but talking in complete sentences | 1. Stop physical activity.<br>2. Give RESCUE INHALER:<br>☐ 2 puffs ☐ 4 puffs<br>3. Stay with child and maintain sitting position.<br>4. REPEAT RESCUE INHALER if not improving in 15 minutes:<br>☐ 2 puffs ☐ 4 puffs<br>5. Child may go back to normal activities, once symptoms are relieved.<br>6. Notify parent/guardian and school nurse.<br>***If symptoms do not improve or worsen, follow RED ZONE*** |
| **RED ZONE**<br>**EMERGENCY**<br>**Severe symptoms** | • Coughs constantly<br>• Struggles to breathe<br>• Trouble talking (only speaks 3-4 words)<br>• Skin of chest and/or neck pull in with breathing<br>• Lips/nails gray or blue<br>• ↓ Level of consciousness | 1. Give RESCUE INHALER:<br>☐ 2 puffs ☐ 4 puffs<br>2. Refer to anaphylaxis plan, if child has life-threatening allergy.<br>**3. Call 911**<br>4. Stay with child. Remain calm. Encourage slower, deeper breaths.<br>5. Notify parent/guardian and school nurse.<br>6. If symptoms do not improve, **REPEAT RESCUE INHALER:**<br>☐ 2 puffs ☐ 4 puffs (every 5 minutes until EMS arrives) |


**CONTINUED**

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# ASTHMA ACTION PLAN
**(CONTINUED)**

| ADDITIONAL MEDICATIONS AT SCHOOL | | | |
|---|---|---|---|
| **1. NAME OF MEDICATION:** | **Dose:** | **Route:** | **Time:** |
| **Symptoms for which to be given:** | | **Possible Side Effects:** | |
| **2. NAME OF MEDICATION:** | **Dose:** | **Route:** | **Time:** |
| **Symptoms for which to be given:** | | **Possible Side Effects:** | |

**PLEASE CHECK THE APPROPRIATE BOXES**

☐Student needs supervision or assistance to use inhaler. Student will NOT self-carry inhaler. Medication in health office.

☐ Student understands proper use of asthma medications, and can carry and self-administer inhaler at school with approval from school nurse.

☐Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

| HEALTH CARE PROVIDER AUTHORIZATION FOR ASTHMA MANAGEMENT AT SCHOOL | |
|---|---|
| My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the District Nurse. This authorization is for a maximum of one (1) year. If changes are indicated, I will provide new written authorization. (May be faxed) | |
| **Physician Signature:** | **Date:** |
| **Physician Name:** | |
| **Address:** | |
| **Telephone:** | |

**PART II: PARENT SECTION**

| PARENT CONSENT AND AUTHORIZATION | |
|---|---|
| I(We), the undersigned, the parent(s)/guardians of the above named pupil, request the following for the Management of Asthma in school be administered to my(our) child in accordance with the California Education Code 49423.5. I will:<br>1. Provide all medications, supplies, and equipment.<br>2. Notify the district nurse if there is a change in the pupil's health status or attending physician.<br>3. Notify the district nurse immediately and provide new consent for any changes in doctor's orders.<br>4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.<br>I authorize the district nurse to communicate with the authorized health care provider when necessary in regards to this specific medication and medical condition. I will be provided with a copy of my child's completed ISHP. | |
| **Parent/Guardian Signature:** | **Date:** |
| **Parent/Guardian Name:** | |

**Principal's Signature:**_____ **Date:**_____

**District Nurse Signature:**_____ **Date:**_____